

**HEALTH ASSESSMENT/SPORTS PHYSICAL STATEMENT (HASPS)
for CYS SERVICES
ENROLLMENT, Renewal & SPORTS PHYSICAL Requirements**

Revised 08Jan 09

DATA REQUIRED BY THE PRIVACY ACT OF 1994

PRINCIPAL PURPOSE: Information is used by DA personnel to: (1) verify child health status of immunization per admission requirements; (2) note special program considerations or restriction on child participation; (3) execute emergency medical procedure for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program; (5) certify physically fit to participate in sports. **ROUTINE USES:** No information is disclosed outside DOD. **DISCLOSURE:** Information is voluntary; however, if information is not provided, individuals may not be able to participate in community activities.

INSTRUCTIONS: All sections A, B, C. must be completed **PART A - Filled out by Parent/Guardian**

PART: A Medical History (Filled out by parent / guardian)

Name of Sponsor	Home Telephone	Duty/Work Telephone
	Cell Telephone	
Sponsor Unit / Work Address PSC 701, Box		Spouse's Work Telephone

CHILD HEALTH INFORMATION

Name of Child	Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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Does your child have ongoing medical concerns?
(If Yes, explain circumstances and current status)

Yes No

Is your child enrolled in Exceptional Family Member Program?
(If Yes, explain)

Yes No

MEDICAL HISTORY

	YES	NO		YES	NO
1. Any hospitalization or operations			14. Heat stroke or exhaustion		
2. Allergies to medicine, insect bites or food			15. Broken bones or sprains		
3. Speech or development delays			16. Joint injuries (Ankle/Knee/Wrist)		
4. Vision Problems (Glasses / Contacts)			17. Required restricted physical activity		
5. Ear or hearing problems			18. Diabetes		
6. Seizures or Convulsions			19. Cancer		
7. Dizziness or fainting with exercise			20. Dental or orthodontic braces		
8. Headaches			21. Learning problems		
9. Head injury or loss of consciousness			22. Sleep problems		
10. Neck or back injury			23. Behavioral problems		
11. Asthma or difficulty breathing			24. ADD / ADHD		
12. Heart or blood pressure problems			25. Autism Spectrum Disorder		
13. Chest pain with exercise			26. Other (please list below)		

If you answer yes to any of the above, please explain:

Ongoing Medications

Name	Dosage	Frequency

Allergies – All Types (Foods, Medicines and Insect Bites)

Type	Reaction

[:Admin\CYS\CYSS Parent Central\Registration Packet\2017 documents\Medical Forms for CYS Registration.pdf](#)

PART B: Physical Exam **This Section filled out by Medical Staff**
 Medical Staff Assessment (Completed by licensed independent practitioner: Doctor-Dr., Nurse Practitioner-NP, Physician's Assistant-PA)

Age YRS MOS	Height _____ cm. (_____ %ile)	Weight _____ kgs. (_____ %ile)
BP: /	Visual Acuity Right / Left /	Tested with without glasses

	NORMAL	ABNORMAL	N / A	COMMENTS
1. Eyes				
2. Ears, Nose & Throat				
3. Hearing				
4. Mouth & Teeth				
5. Neck (Soft tissues)				
6. Cardiovascular				
7. Chest & Lungs				
8. Abdomen				
9. Genitalia – Hernia				
10. Skin & Lymphatics				
11. Spine – Scoliosis				
12. Extremities				
13. Neurological				
14. Wears braces / plates				

Based on this HX and PX exam, the following abnormalities were found and may need treatment:

Immunizations are current and up to date: Yes No

PARTICIPATION RECOMMENDATIONS

All sports ____ Yes ____ No Normal physical activity to including PE

Additional comments: Restrictions:

Sports Physical is valid for 1 year from date indicated below

PART C **This Section filled out by Medical Staff and Guardian**

Special Medical Considerations: Describe any special program needs, considerations or restrictions which the child requires in order to participate in CYS programs (to include Sports).

Child / Youth is able to participate in normal CYS programs? Yes No

Date	Licensed Health Care Professional Stamp	Licensed Health Care Professional; Dr., NP or PA Signature

Initial Date	Type or print name of Parent or Guardian	Signature of Parent or Guardian

HASPS Renewal (Not Part of the Sports Physical)

Year 2 Date	Health Status Changed	Signature of Parent or Guardian
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Year 3 Date	Health Status Changed	Signature of Parent or Guardian
	<input type="checkbox"/> Yes <input type="checkbox"/> No	

ARMY CHILD AND YOUTH SERVICES HEALTH SCREENING – TOOL #1

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 3013, Secretary of the Army; 29 U.S.C. 794, Nondiscrimination Under Federal Grants and Programs, DoDD 1342.17 Family Policy; AR 608-75, Exceptional Family Member Program; AR 608-10, Child Development Services; and E.O. 9397 (SSN).

PRINCIPAL PURPOSE: Information will be used to assist Army activities in their responsibilities in overall execution of the Army's Exceptional Family member Program (EFMP) and the Army Child and Youth Services Program.

ROUTINE USES: The DoD "Blanket Routine Uses" that appear at the beginning of the Army's compilation of systems of records apply to this system

DISCLOSURE: Disclosure of requested information is voluntary; however, if information is not provided individual may not be able to participate in Army Child and Youth Services Program.

SNAP Case Number: _____

FOR CER COMPLETION ONLY

- Initial Registration
Is child on waiting list? Yes No
Date care needed? _____
- Re-registration/Child Already in Program
 Change in Program

Date in from Patron: _____

Date out to APHN: _____

Part A – General Information

Child/Youth Name	Child/Youth School Grade (example: 3 rd Grade)	Date of birth (YYYYMMDD)	Age
Type of Placement Requested: (check all that apply)			
<input type="checkbox"/> Hourly Care	<input type="checkbox"/> Full Day Care	<input type="checkbox"/> Middle School/Teen Program	<input type="checkbox"/> Summer Camp
<input type="checkbox"/> Part Day Care	<input type="checkbox"/> Before/After School Care	<input type="checkbox"/> SKIES/Instructional Classes	<input type="checkbox"/> Other: (specify) _____ Open Rec/4H
Sponsor Name		Sponsor E-mail	
Spouse Name		Spouse E-mail	
Home Phone		Work Phone	Company
Home Address PSC 701, Box		Other: _____	

Part B – Identification of Child/Youth Condition/Restrictions

Does your child have any of the following conditions/restrictions: (check no or yes and answer questions as appropriate)

<p>1. Allergies</p> <p>a. Life threatening reaction? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>b. Rescue Medication (Epi-pen, Benadryl, Inhaler) <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>c. Does child/youth need rescue inhaler? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If your child/youth has an allergy, please list: _____</p> <p>Reaction: _____</p> <p>2. Special Diet</p> <p>a. Is your child on a complex diet (i.e. gluten free, diabetic) <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>b. Does your child have a food intolerance/mild food allergy (i.e. rash from strawberries/milk intolerance)? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>c. Does your child have a dietary religious restriction? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>3. Asthma/Reactive Airway Disease/Breathing Problems? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>a. Does your child need a rescue med? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>4. Does your child have diabetes? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>5. Does your child have seizures? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>6. Attention Deficit Disorder (ADD/ADHD)</p> <p>a. Are there behavior/conduct concerns while on meds? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>b. List ADD/ADHD medications: _____</p> <p>_____</p> <p>_____</p>	<p>7. Behavior/ conduct concerns (oppositional defiant disorder, anxiety, depression, bipolar, other)? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>8. Autism Spectrum Disorders (Autism, Aspergers, Rett Syndrome, PDD-NOS) <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>9. Does your child have any of the following health concerns? (circle all that apply)- Hearing impairment, vision impairment other than corrective lenses, heart, kidney, physical disability SEVERE skin condition <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Please specify _____</p> <p>10. Does your child have a speech/language and/or hearing loss that affects their ability to communicate their basic needs (hurt, bathroom, fear, thirst)? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Explain: _____</p> <p>_____</p> <p>11. Does your child have developmental delays other than MILD speech language/MILD hearing loss? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Explain: _____</p> <p>_____</p> <p>12. Are there any other conditions or concerns that you would like staff to be aware of? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Explain: _____</p> <p>_____</p>
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Part C – Medications

List any medications that are prescribed for your child/youth other than those listed above:

Will your child require medication administration during child care/youth supervision hours? No Yes

Part D – Early Intervention and Special Education

Does your child/youth receive special services/therapies? <input type="checkbox"/> No <input type="checkbox"/> Yes Please specify: _____	Does your child/youth have an Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP) or 504 Plan? <input type="checkbox"/> No <input type="checkbox"/> Yes
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Part E – Exceptional Family Member Program (EFMP) Enrollment

Is your child enrolled in the EFMP? No Yes If yes, specify for what condition: _____

Printed Name and Signature of Parent/Personal Representative of Child/Youth

Date (YYYYMMDD)

If you have answered NO to all the questions above you are now finished with this form.

Please sign and date indicating that the information above is accurate and complete to the best of your knowledge.

Child, Youth and School Services strives to provide the safest and healthiest environment for your child/youth and relies on your accurate and honest information to support this goal. Please understand that placement and/or care for your child/youth could be delayed/suspended if information is falsified or intentionally omitted on registration documentation. If there are any changes to your child/youth's health please notify CYS Services immediately.

If you answered YES to any of the questions above, complete Part F on the next page.

Form Updated 11 Mar 09

Child/Youth Name	Date of birth (YYYYMMDD)	Age
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Part F – Release of Information

I authorize Kwajalein Hospital (name of Medical Treatment Facility or physician's practice) to release any medical information regarding my child _____ (name of child) to the CDC, Central Reg (name of installation) Child & Youth Services (CYS) Special Needs Accommodation Process (SNAP) personnel and their staff that is necessary to conduct SNAP review. This authorization will remain in effect for one year. I understand I may revoke this consent in writing at any time before expiration, but any action taken by the SNAP on this authorization prior to revocation is valid and will remain in effect.

I understand that information disclosed pursuant to this authorization is For Official Use Only (FOUO) and may be subject to redisclosure. I understand that information redisclosed is no longer protected by DoD 6025, 18-R; however, confidentiality of this information will remain protected by the Privacy Act of 1974, 5 U.S.C. section 552a.

The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.

Printed Name and Signature of Parent/Personal Representative of Child

Date (YYYYMMDD)

Part G – Army Public Health Nurse (APHN) Review

Current Medications other than those listed on page 1:

Diagnosis: _____

Background/Notes:

Medical Records Reviewed? No Yes Not Available

Training for CYS Staff/Provider Required:

Recommendation Summary:

SNAP REQUIRED: No SNAP required Modified Full Annual Review (No team meeting required)

Requirements Prior to Placement:

Medical Action Plan reviewed by APHN: Respiratory Allergy Seizure Diabetes Special Diet
 Other _____

APHN Printed Name or Stamp	APHN Signature	Date (YYYYMMDD)
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Date Received by APHN	Date Returned to CER:
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Form Updated: 11 Mar 09

SPECIAL NEEDS ACCOMMODATION PROCESS (SNAP) ACTION PLAN – TOOL #2

(copy to be kept in child/youth's care module)

Child's Name	Date of Birth (YYYYMMDD)	Date of SNAP
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Diagnosis:	Date of Annual Review:
Approved for the following CYS Program: <input type="checkbox"/> All CYS Programs/services <input type="checkbox"/> CDC <input type="checkbox"/> FCC <input type="checkbox"/> SAS <input type="checkbox"/> Middle School/Teen <input type="checkbox"/> Sports <input type="checkbox"/> SKIES/instructional classes <input type="checkbox"/> Other: _____	

Approved for the following CYS Service:
 Hourly
 Part Day
 Full Day

RECOMMENDATION		
<input type="checkbox"/> IEP goals/interventions	<input type="checkbox"/> IFSP goals/interventions	<input type="checkbox"/> Copy of 504 goals/interventions
<input type="checkbox"/> Copy of Behavioral Assessment/Plan		
<input type="checkbox"/> Copy of MAP Type: _____		Other: _____

Medications: (only list medications to be administered while child is at the CYS program site)

Activity Restrictions/Adaptive Equipment, etc:

Training for CYS Staff/Provider Required:

Recommendation Summary:

I concur with this plan as outlined above.

Printed Name & Signature of EFMP Manager, Chair SNAP Team

Date (YYYYMMDD)

Printed Name & Signature of Child/Youth Services Coordinator/Designee

Date (YYYYMMDD)

Printed Name & Signature of Army Public Health Nurse

Date (YYYYMMDD)

Printed Name & Signature of Parent

Date (YYYYMMDD)